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ABSTRACT

The packet of information is intended to help residential workers with disturbed children in the United Kingdom. The first section on theory contains two papers: "Which Children Come Into Residential Care?" (Robin Benians); and "Models of Treatment: Behavioral, Psychodynamic, Cognitive" (Daphne Lennox). The next section contains practical guidance directly related to the therapeutic management of disturbed children with subsections on the basic needs of children, reasons for stealing, innate conflicts in residential placement, and the child in relation to the family and community. The final section contains materials for use in training and discussion including a school evaluation form covering educational arrangements, care arrangements, and staffing/accommodation/resources. (DB)

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RESIDENTIAL WORKERS' PACK

Alan Rimmer, Editor

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Association of Workers for Maladjusted Children

INTRODUCTION

Reasons for this booklet being produced.

Residential workers with disturbed children find difficulty in getting hold of useful information and access to any form of training. Their task is a demanding one as they find themselves faced with the demands and challenges of unhappy and insecure children without having any established tradition to rely on or much in the way of guidelines.

There is very little written material about residential work and what there is can look daunting. We offer this pack in the hope that it will meet the need for something simple, straightforward and adaptable.

Disturbed Children.

Despite moves towards treatment in the community there is no doubt that a fairly constant percentage of disturbed children will continue to find their way into residential placements. These children will have a range of developmental problems, difficulties in relating to others, considerable domestic stress, an unhappy educational history and a conspicuous loss of personal confidence.

There are basic needs appropriate to all those who are in residential care, from the very old to the very young. These basic needs must be met, but our children also have special needs and require a degree of patient and understanding skill of a very specific kind.

Although there has been some reduction in residential provision the steady rise in the number of disturbed children will undoubtedly continue and probably reverse this trend over the next decade. Residential provision is here to stay, but it must accept the need for assessment and accountability if it is to maintain its position as one of many ways of treating emotionally and behaviourally disturbed clients.

Design of this Pack.

At first we thought in terms of a simple handbook but it became clear very quickly that this could not be done, not least because different practitioners will interpret and react to situations in very different ways according to their school of thought or therapeutic beliefs.

The answer was to assemble a pack of material in order to try to find out whether this would meet the needs of workers without being directive or committed to one philosophy or another. From the mass of material that we got together we have seen three distinctive kinds of material emerge and this has given the structure which we are using. If this is successful we will use it for further material. The structure is

A. Theory: short articles on issues of importance to residential workers.

B. Teaching: contributions directly related to the therapeutic management of disturbed children.

C. Ephemera: useful projects, worksheets and other material to be used as training or discussion material.

We also felt that some material had been presented which would not, for various reasons, form part of the main pack but which could be available as a series of Annexes. These would be available in response to particular request.

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In producing this pack we feel that we are breaking new ground. We see its main function as fostering communication and awareness among those engaged in a difficult and vitally important job. If we are to succeed we will need feed-back from workers to let us know what they feel about this pack and what they want from us. Please use the feed-back sheet inserted in this pack.

A.W.M.C. Residential Pack

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Which Children Come Into Residential Care?

by

Robin Benians.

1. Introduction

Historically it has been children of the poor and abandoned children who have come into the care of the parish, if they survived. Today the staff of residential homes for children have to cope with children for whom other forms of care have failed.

Percival, writing in 1911 in "Poor Law Children",[1] traced the upsurge of interest in child welfare that developed in Victorian England to rectify barbaric practices of sending children from poor law institutions to industrialists who worked them, literally, to death and then went back to the workhouse for more. Another way of dealing with pauper children was to send them in groups to the colonies to work. In 1946 the Curtis Report[2] reviewed work with children in all types of residential settings and demonstrated the wide variation of quality in the work. More detailed insights into residential work with children may be gained from Conway[3] and Wolkind.[4]

In recent years statistics for England and Wales show that there are at any one time about 100,000 children in the care of local authorities placed in substitute care of various kinds. About 60 or 70% return home within two months. In addition, a similar number reside, mostly by voluntary agreement, in special residential schools so that their care is shared between professionals and their families. Government pressure has led to the use of foster homes as the preferred placement for children who can no longer be cared for by their own parents.[5] Some local authorities claim that no child below the age of twelve within their boundaries will ever enter a residential home. The renewed drive to foster and government demands to reduce public expenditure has meant a reduction of resources for residential work. This has led to an unwarranted lowering of status for workers in residential settings. Nevertheless it is residential workers who always remain the backstop of care for children since it is to residential care that children have to go whenever insuperable crises occur in any other setting. Children come into residential care from families that can no longer cope, often families headed by one parent, from disruption of placement in special residential schools, from disruption of foster placements and, from time to time, from disruption of adoptive placements.

Recent research in a large inner London borough has revealed that receptions into care from any source dropped 14% as a result of the setting up of Family Resource Centres. These are places where, at any time of day or night, troubled families may go for help, advice and even to request that a troubled or troublesome family member may stay overnight to relieve a crisis within the family. There are six family resource centres and one Family Service Unit in the borough concerned.

2. Routes into residential care.

Most children enter care from ordinary families and return to them. However, children from families headed by a single parent, often an unemployed single parent, are more likely to come into long-term care. Other factors include chronic mental or physical illness or handicap of one or both parents. Often there has been a crisis to precipitate the child into care, such as death or hospitalisation of a parent, imprisonment of a parent, desertion of a parent, separation or divorce, or the bread

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winner having to work a long distance from home. Sometimes factors associated with the child cause reception into care, such as persistent behaviour problems, anti-social conduct or the rebellion of adolescence.

Family breakdown may be precipitated by a lack of supporting relatives and friends, distance or alienation from extended family. Immigrant families seem specially vulnerable.

Children who already have difficulties with relationships may be placed away from home in special residential schools so that their care is still provided by their own parents for short spells such as school holidays, half term and some weekends whilst the larger part of their care is provided by residential social workers or specialist teachers. Some of these children may develop further problems, usually of rebellion, when they enter adolescence. Whilst most will be coped with at their school some prove too much for the most skilled and experienced staff and have to be excluded. A few may return to their own homes but many will need a place in a residential home.

One cause of failure of placement of children in long-term foster homes and some adoptive homes lies in a lack of adequate assessment before placement of how disturbed the children are and the quality of relationship, or lack of it, they are capable of giving. Further failures arise because no estimate has been made about the capability of foster parent applicants to benefit from case work if behaviour problems persist or arise in the children to be placed with them. Clinical experience suggests that many foster parents are reluctant to seek or accept help from agencies such as child guidance clinics where family relationships can be assessed and worked with. When a foster placement breaks down the child becomes the responsibility of the placing authority. However, when an adoptive placement breaks down the child is more likely to become the responsibility of another local authority - unless the adoptive home happened to be within the area covered by the placing authority.

3. Some statistics.

During 1980 I carried out a small survey at ten long-term residential children's homes to find out what proportion of children had experienced a failed foster placement. There were no pre-school children in any of these homes. Of 136 children of school age (5-16 years) 29 (21%) had experienced at least one foster home breakdown. Of 36 children over the age of sixteen, 19 (53%) had had similar experiences. Over the whole group 48 (38%) of 172 children and young people had experienced one or more failed foster home placements.[6]

During 1985 one large outer London borough had a total of 40 residential places for children in 3 homes that covered different but overlapping age ranges. There was no reception, observation or assessment centre. During 1985 a total of 113 children were placed in these homes from the the sources listed below:

Admitted from own family (some headed by one parent)	80
Admitted from foster parent	12
Admitted from other residential establishment (CHE, Regional home etc.)	11
Admitted from Police	8
Self admissions (refused to return home)	2
Total	113

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Another outer London borough (Ealing) admitted 131 children to residential establishments during the same period:-

Reason for placement	N	%
Holiday placements from school	10	8
Disrupted foster placement	3	2
Disrupted special school placement	3	2
Breakdown of family	77	60
Hospitalisation of mother	27	20
Remands in care	11	8
	131	

4. Conclusion.

There is no doubt that workers in residential homes for children need to be of the highest quality, to have had the most extensive training and require the best quality of backup available, especially with regard to caring for children in long-term care. By definition, every child or adolescent entering a long-term residential home is highly likely to have passed through numerous settings, to have contributed to the breakdown of those settings, to be cumulatively disturbed by each disruption and the depression that follows, and to be in need of more assistance than any other young people if they are to achieve some level of independence by the time they reach adulthood.

5. References.

1. Percival, T., (1911) "Poor Law Children" London:

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4. Wolkind, S., (1972) "Children in Care, A Psychiatric Study". M.D.Thesis: University of London.

5. "Provision of Child Care at Eight Local Authorities in England and Wales" Bristol: Audit Commission (1981).

6. Benians, R., (1980) "Failed Fostering Placements" Adoption and Fostering Vol. 101, No. 3, p.3 and p. 50.

Models of Treatment

by

Daphne Lennox

Introduction.

When we use the expression 'models of treatment' there is some assumption that - just lying around, if only we could stumble upon them, are magic formulae which will make our task of understanding and helping the maladjusted children in our care relatively straightforward and easy.

Unfortunately, after twenty-eight years of searching for, and discovering and experimenting with, some of the 'models' which have come into and out of fashion, I no longer believe in magic!

I do believe, however, that it is of value in this confused and confusing setting of relationships and inter-relationships, reactions and inter-reactions in which we live and work, to examine some of the theoretical bases which have been the outcome of long-term research and practice in the residential care and education of maladjusted children.

We may accept one of these models as our gospel or reject them all out of hand. We may, especially if we have reached that rather boring stage of personal intellectual insight called 'eclecticism', decide to take from each model what seems suited to a particular child in a particular situation - bearing in mind our own personal strengths and limitations in putting theory into practice!

Within the scope of this short article it will be possible to examine only very superficially three of the myriad approaches to treatment in the knowledge that, if the reader's appetite has been stimulated, there is no shortage of longer articles and books which may be of help to interested practitioners.

As has been suggested in Allan Rimmer's article on the concept of a therapeutic community, all effective residential treatment, whatever the theoretical basis, will take place within an environment which is totally designed to effect that treatment, and this is equally true of day treatment.

What makes us, then, as individuals or as a collective staff group, decide to work in one way more than in any other?

At the risk of grossly over-simplifying the answer to this question, I would suggest that explicitly - or, more often, implicitly, we are drawing on a personal belief as to the nature of why and how we think, feel and behave as human beings and, therefore, in what ways it is most possible and effective to bring about change.

All models of treatment acknowledge the existence of feelings, thoughts and observable behaviour. Where they differ is in the order of importance in which they place these three areas of human experience, i.e. do we behave and think because of the way we feel, do we behave and feel because of the way we think, or do we feel and think because of the way we have learnt or been taught to behave?

The three models of treatment I have chosen to describe very briefly - Behaviour Modification and Therapy; Psychodynamic Therapy; Cognitive Therapy - illustrate how different models place emphasis on change in one of these three major components of human functioning, i.e. behaving, feeling, thinking, in the belief that positive and constructive change in this one area will automatically bring about similar change in the other two.

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Owing to the limitations of length, I shall concentrate more on a description of the Behaviourist model (as I have been asked to do!) Although this is not perhaps my strongest personal bias, I do feel that learning theory has made a significant contribution to my attempts to understand and help maladjusted children. I will include, however, a very sketchy outline of the psychodynamic and cognitive approaches as I feel strongly that it is unwise to think of one approach exclusively, without, at least, passing reference to the other two.

The Behaviourist Model

A key to understandint the Behaviourist approach is the belief that all behaviour is learnt and that, therefore, it is possible for therapists to help children to 'unlearn' undesirable behaviours and to learn new behaviours which are socially acceptable and rewarding to the child.

Behaviour therapists base their concept of treatment on learning theory which, inspired originally by the work of pioneers such as Pavlov with his experiments on teaching dogs to salivate at the sound of a bell, having previously paired the sounding of a bell with the offering of food, developed along three major lines. The first was behaviour modification, based on the work of psychologists led by B.F. Skinner (1974) which employs techniques of operant conditioning, often through the use of a token economy. The second was systematic desensitization derived originally from the works of Lazarus and Wolpe (1960, 1966). The third was modelling based on the work of Bandura (1977).

We will take a brief look at these three aspects of Behaviourist Therapy in order to question in what ways, if any, the techniques involved can help us in our attempts to treat emotionally and socially disturbed children in our care.

Behaviour Modification.

Skinner's major hypothesis is that it is possible to change children's undesirable behaviour by manipulating the learning experiences through which that behaviour was acquired in the first place and to increase potential desirable behaviour through similar techniques. He believes that all our behaviour, and consequently the way we think and feel, has been conditioned from birth onwards by the responses we have received from our environment, i.e. the important people specially close to us, as well as the demands of our cultural and sex roles.

For example, if we take a piece of undesirable behaviour common to the children in our care, continuous and inappropriate bed-wetting, he suggests that this behaviour has been learnt as a direct response to the attention given to it by a worried and often frustrated and angry mother who has to wash sheets daily!

Many of the children referred to us have learnt that the only way in which to receive any kind of attention is through anti-social behaviour - and any form of attention, even being 'told off' or punished is better than no attention at all.

If we accept that this type of behaviour has persisted because it has been reinforced by constant attention, Skinner suggests that we can re-direct this very real and normal need for attention by reinforcing any attempts at desirable behaviours and ignoring undesirable behaviours.

This process of reinforcing the behaviours the child needs in order to be a well-adjusted member of his own family, peer group, and wider society was labelled by Skinner 'Operant Conditioning', and it is one of the main tools of behaviour modification.

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I have often heard staff in communities for maladjusted children say that they have been using behaviour modification for years. By this they are referring to the model of treatment where there is an organised system of rewards for good behaviour and punishment or loss of privileges for bad behaviour - the carrot and the big stick.

In true operant conditioning, only the desired, or approximations of the desired behaviours are recorded and rewarded so that privileges and treats can only be gained and not taken away. For example, if one is attempting to help a child to stop bed-wetting he will receive praise or rewards when his bed is dry but no attention will be given to the occasions when his bed it wet. The undesirable behaviours are, to the best of one's realistic ability, ignored, on the basis of the theory that if he does not receive attention for these behaviours, the child will learn to use more constructive stratagies for gaining approval, affection and rewards.

In setting up a behaviour modification treatment model on this theory it is important to remember that the focus is not on the child's underlying personality characteristics, conflicts, traits, feelings and thoughts but on determining the nature of the observable behaviours that have led the child to be considered maladjusted and the nature of the environmental factors that have produced and maintained those behaviours.

Token Economy.

These principles of behaviour modification can be employed, in a treatment setting, through what has come to be known as a token economy system. This system is called an economy because it deals in 'payment' for specified desirable behaviours. The word 'token' is used because the system employs tokens, such as stars on a chart, which can be exchanged for tangible rewards or direct material rewards. The word 'token' is appropriate not only because it is sometimes tokens, like trading stamps, which are used to reward desirable behaviour, but also because these rewards are tokens, i.e. 'symbols' of approval. A token economy model aims at using tangible tokens of approval for desirable behaviour in the short term with the long term aim of helping the child to understand that approval and acceptance for his good behaviour is rewarding in its own right and that he no longer needs the symbol of 'goodies' to help him to maintain that 'good behaviour' and display it in all situations, not just in his treatment setting.

The major characteristics of a token economy are: (a) the identification of behaviours to be modified, referred to as 'target behaviours'; (b)examination of the system of reinforcement which formerly caused and maintained those behaviours; (c) determination of the forms of positive reinforcement or rewards which are likely to be successful in producing desirable behaviour; (d) designing for and with the child and all staff concerned with him a highly-structured programme of monitoring his behaviour and rewarding, in the agreed manner, his attempts and successes in demonstrating the behaviours to be modified; (e) weaning the child away from the strict token economy programme when the desired behaviours have become natural and spontaneous to him in all situations.

Let us now examine each of these steps in slightly more detail:

(a) Behaviours to be modified:

When considering our target behaviours for maladjusted children the whole ethical question of whether it is morally sound to attempt to condition the behaviour of other human beings naturally springs to mind. Behaviourists would argue, however, that, it we engage ourselves in the 'change business' of therapeutic intervention with maladjusted children, this question is equally valid, no matter what treatment model we select, and that behaviourists

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at least try to be as objective as possible by concentrating only on what is directly observable and not speculating, subjectively, about inner causes, and hidden motivations underlying maladjusted behaviour.

Before identifying and selecting pieces of behaviour to be modified it is important to be aware that our aim is to help the child to behave appropriately, and with happy results, in his own personal and home environment and not just in the 'institution' in which we have placed him for treatment!

It is also vital to select behaviours which can be observed easily and recorded in concrete form. For example, it is not enough to state as a behavioural goal that a child should learn to 'get on' with other children. His behaviour must be observed, over a long enough time, to determine the exact behaviours which prevent him from 'getting' on with his peers. He may hit other children, interrupt them when they are talking, tell lies, or steal from them.

The first monitoring and recording of the frequency and intensity of the child's unhelpful behaviours is called 'creating a base line' and it is the first essential step to take before planning a programme of behaviour modification. The behaviours to be observed can be recorded on an hourly basis or the day can be broken up into longer intervals, e.g. morning, afternoon, evening (if residential). The observer must be meticulous and systematic in his recording otherwise it will be impossible to monitor and measure any progress made during treatment. Decreasing the observable frequency and/or intensity of these base line maladapted behaviours, and increasing the child's repertoire of desirable behaviours, is the aim of our treatment.

(b) <u>System by which target behaviours were formerly caused and maintained</u>:

In order to determine this, it is necessary to have some knowledge of what has preceded the child's admittance to us as someone in need of help. For example, many a child comes to us with a complete incapacity to control his temper. Information about the home situation may reveal that this is because his parents have always, when the child has had a temper tantrum, given in to his irrational demands and made him feel that he is the only important member of the family.

At the other extreme, we may find that the parents have had so little time or inclination to give attention of any form to their child that he has learnt that, in order to attract some attention at least, it is effective to throw a temper tantrum.

Knowing simple facts such as these will influence, significantly, the system of positive reinforcement we decide to employ to strengthen desirable behaviours and weaken the undesirable.

(c) <u>Determining a system of positive reinforcement:</u>

To continue with the former example, the first child is well used to unconditional acceptance from his parents, especially for the undesirable temper tantrums which have led him to be sent to us. Positive reinforcement in this child's case will consist of refusing to give any attention whatsoever to the child's outbursts of temper and of rewarding heavily any small attempt which he can be seen to make to control his own temper.

The second child, though equally out of his own control, has been deprived of any attention for good behaviour and, therefore, although it will still be policy not to reward him with attention for temper tantrums, there will be much more need to provide him with opportunities to behave in ways which will earn him genuine approval and rewards, e.g. making him your special helper in some area (the traditional board monitor!) so that he can rehearse,

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and be rewarded heavily for, behaviours which emphasise his worth to you and, consequently, to himself.

The actual tokens or rewards used in behaviour modification programmes will vary with the child's concept of what he considers to be a treat. For one child it may be sweets; for another, going out on a shopping expedition with his favourite member of staff; for another, being allowed to spend time on his own, e.g. fishing. A star chart or equivalent is often used to record each successful piece of behaviour then these stars or 'tokens' will have an agreed value and can be traded in for the kind of rewards suggested previously. For example, a child may need to trade in ten tokens for an outing to the pictures and five to be allowed to stay up an hour later at night. The 'exchange rate' for tokens will be known, and usually agreed upon, by all children and staff involved, and consistency and fairness are the keys to success.

(d) Designing the programme:

The programme of behaviour modification for a particular child and his identified maladaptive behaviours will already have suggested itself through taking the three preceding steps outlined briefly above. The details of the target behaviours, forms of rewards and the whole system of treatment should now be discussed with the child, possibly his peers if the token economy is a group process, and, essentially, with all staff involved with the child and, wherever possible, his parents. Consistency is the keynote of successful behaviour modification and one cannot exaggerate the importance of staff being structured and co-operative with one another so that they will not, unintentionally, be cutting across a carefully designed programme of positive reinforcement.

Much more detailed accounts of scheduling and varying the use of positive reinforcers and monitoring and recording progress can be found in the literature, e.g. Blackham and Silberman (1971), Lennox (1982), and should be explored if the reader wishes to attempt this method of treatment.

The Weaning Process.

There have been many experiments to prove that, whilst engaged in a token economy programme, the behaviour we think it will be helpful for a child to learn can be successfully conditioned. As the child is being rewarded visibly for that behaviour, is he just responding to the system, i.e. 'playing the system' for his own ends or has that desirable behaviour become a natural part of his repertoire of behaviours and will he continue it once we stop 'rewarding' him for it with tokens and reward him with our approval - or even just with our lack of disapproval?

This is the million dollar question when we come to measure the success of our programme of behaviour modification and will depend on how successfully we have been able to wean the child away from dependence on a token economy.

The weaning process, as the expression implies, will be gradual and will consist of a systematic decrease in the use of tokens and a transfer to the use of praise, then approval - not necessarily spoken.

Follow-up studies, several weeks and months after the token economy programme has finished will, hopefully, prove that the new set of behaviours has, in fact, been learnt and that we have genuinely helped the child to behave in a more acceptable way and, therefore, to think of himself as a more worthwhile person and to feel happier with life.

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Systematic Desensitization.

Systematic desensitization, derived from learning theory, has been used, very successfully, by behaviourists, particularly in their work with children who suffer from extreme anxieties and phobias, see, for example, Patterson (1965).

The term 'systematic desensitization' means the planned use of exposing a child, in graduated steps, to the situation or object which gives him extreme anxiety.

In the first stage of the treatment the child is taught deep muscle relaxation, see Rose (1973: 129). The therapist then asks the child to list all the stimuli which arouse fear in him and these are arranged in a hierarchy from the least to the most disturbing.

While in a state of relaxation, the child is then asked to imagine the least disturbing situation with reference to his particular fear or phobia, e.g. of spiders or of going to school, and encouraged to talk about it, and then to progress step by step to the most disturbing. For example, if a child has a fear or phobia about water and swimming, the first step would be to talk to him about it and perhaps look at pictures or films of people swimming. The next step might be to take the child to the baths and let him watch other children swimming, then to introduce him to the water itself by letting him paddle in the shallow end and so on.

As each new step is taken, however small, it is rewarded and praised and gradually the child learns to overcome the fear independently from the therapist.

Anyone interested in using this form of behaviour modification should refer to the work of Wolpe and Lazarus (op.cit.) and the experiments conducted by practitioners - possibly one's local educational psychologists or child psychiatrist.

Modelling.

All cultures use models to transmit their concept of desirable behaviour patterns and value systems to the rising generation and it is the manipulation of children's natural propensity for 'copying' others which is termed 'modelling' in behaviour therapy.

The most powerful models for children in a treatment centre are the staff themselves. If we cannot demonstrate acceptable behaviours and attitudes amongst our staff group, e.g. respect, tolerance, empathy and humour, it is unlikely that children will display these qualities and the behaviours associated with them.

It is also important that the staff we select provide a wide variety of credible family and sex roles on which the child may model himself. If all the staff are as anxious, aggressive or neurotic as the children they are treating then they are unlikely to be modelling, in their own behaviour, the behaviours they are striving to condition in the children. Many examples spring to mind: using corporal punishment to stop a child hitting another child; smoking; swearing - "We'll have no bloody swearing in this establishment"!

The other most powerful models for children are the other children, their peer group. By seeing the consequences, both good and bad, of other children's vehaviour a child can learn rapidly from this.

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As well as having a balance of male/female, adjusted introvert/adjusted extrovert on the staff is helpful, where this is practicable, to have similar balance within the children group. This is where I would advocate, strongly, co-education, mixed age and sometimes ability grouping and mixed 'problem' grouping.

If the modelling is taking place within a token economy, it is possible to 'pair' a child who is earning many tokens with a child who is not, on the basis that the first child's behaviour will provide a suitable and encouraging model for the low achiever.

Another example of the use of modelling is when we deliberately place a child who is shy and withdrawn in a group of more extrovert children, and vice versa.

The provision of modelled behaviour for a child to imitate can therefore be used (i) to inhibit or disinhibit responses which the child already possesses; (ii) to help him to acquire new skills; and (iii) to bring out latent talents and constructive behaviours.

Summary.

In this section we have taken a brief look at some of the ideas - operant conditioning, token economy, systematic desensitization, and modelling, which the behaviourist model has to offer. What I would wish to add, in conclusion, is that, whereas behaviour modification in particular has often been seen as a powerful, effective and sometimes dangerous way of 'controlling' children's conduct and eliminating anti-social behaviour, it also has much to offer in the way in which it provides opportunities, through positive rewards, for a child to develop self-confidence, self-worth, new skills and new feelings and thoughts about himself.

The Psychodynamic Model

A key to understanding the psychodynamic approach is that treatment is focussed, primarily , on feelings, although new thoughts or 'cognitions' do eventually play a part when the child gains insight into himself and, if the treatment is successful, his behaviour becomes less maladjusted.

This emphasis on feelings or emotions goes back to Freud's early work in psychoanalysis when he concentrated, with his patients, not only on the recall, through free association, of repressed memories but also on what he called 'cathartic abreaction', i.e. the letting 'go' or 'out' of emotions which had hitherto been blocked.

I think most of us, from our work with very unahppy or aggressive children, have experienced the sense of relief a child may convey when he, usually after a build up of 'difficult' behaviour, breaks down and shouts out, or whispers,the real anger he feels for perhaps a cruel or neglected father.

Equally, some children need 'permission' to show positive feelings towards a close family figure and again will experience relief when, finally, they allow themselves to express the repressed love and need they have for, perhaps, a mother who has always been painted to them as wicked or inadequate.

When we decide to work on a psychodynamic treatment model we offer ourselves to the child as people whom he can, temporarily, use as substitutes for the close, significant adults with whom he finds difficulty in relating - usually a member of the family or substitute family.

The type of relationship we form with the child in this situation is called a 'transference relationship' which, as the name implies, means that he will transfer onto us, early in treatment, the strong feelings of love, hate, anger, frustration, he feels, not for us personally (we hope!) but for his

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real parents. He will re-enact these feelings with us, in a comparatively 'safe' relationship, before he goes onto the next stage of treatment when he will start to put those feelings of, e.g. love or hate, where they really belong.

To be able to sustain a warm, accepting, loving relationship with a child who is going through this painful, emotional process of treatment it is vital that staff receive emotional and professional support themselves so that they do not get caught up in the transference relationship to the extent that they themselves start to feel 'bad' or 'hurt' or 'angry' at the injustice of it all and start to react towards the child as if they were, indeed, the bad parents the child is perceiving in them and projecting on to them.

Even after years of experience it is difficult to accept the 'bad' feelings which a child may project onto you when he sees you as his 'bad'parent' and not as the caring, accepting, understanding adult whom you are sincerely trying to be.

One has to make a determined effort, with good professional support, to stay in the benevolent role and not to enter the destructive counter-transference relationship the child is trying to force you into in his efforts to avoid emotional change, which may seem threatening to him. In this situation it is more difficult than one would think not to react to the child in exactly the way his real parents have done.

It is perhaps even harder not to fall into the 'counter-transference' role, i.e. the role in which the child places you as if you were really his parent, when he chooses to do the opposite and makes you the 'goodie'.

Most of our maladjusted children see people as either 'black' or 'white' - 'good' or 'bad'. When a child chooses to put us in the 'good', perfect, idealised parent role it is even more tempting to fall into a counter-transference relationship with him as, being only human, this unquestioning adulation can be very flattering to our own egoes!

Although the psychodynamic approach certainly lays emphasis on the free expression of feeling and emotion it requires as structured a framework as behaviour modification when it comes to building in regular staff support, consultation, treatment planning and evaluation if we are to help a child to live with his ambivalence about his parents i.e. his capacity to both love and hate them at the same time, and to see them, and people in parental roles, as sometimes 'black', sometimes 'white' - but, more often than not, as 'grey'.

We all find it difficult to accept the principle of ambivalence in life, i.e. the capacity to both love and hate the same person, especially someone to whom we are emotionally close. Maladjusted children and their parents have even more than the average difficulty in accepting this principle and it is part of our task as therapists, especially if we are working on a psychodynamic model, to help our families to feel less guilt about this ambivalence and to accept, own, and express appropriately these normal feelings of deep love and controlled anger when they arise.

When I mentioned earlier that change may seem threatening to a child, even though he is desperately unhappy in his present situation, I was referring to the fact that all change has an element of anxiety about it, even change for the better!

Although the psychodynamic approach to treatment lays emphasis on all the emotions, it is mainly neurotic anxiety which leads to the child defending himself in unrealistic ways, e.g. seeing all adults as either good or bad, and which leads him to be deemed maladjusted.

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A certain degree of anxiety, about real threats to our physical and psychological security is inevitable and even necessary in life. It is the neurotic anxiety we experience when we feel that our natural impulses and instincts seem to be out of control or when we are exaggeratedly plagued by guilty anxiety that causes us to seek temporary, but in the end, unrealistic ways of fending off this type of anxiety.

These unrealistic methods of dealing with neurotic anxiety were dubbed, by Freud, the Defence Mechanisms.

All defence mechanisms share two common features: (a) as they operate at an unconscious level they are self-deceptive, and (b) they make the anxiety less threatening to the individual by distorting the perception of reality.

Some examples of defence mechanisms are 'projection', i.e. attributing to other people attitudes and behaviours which are really one's own; 'repression', i.e. a refusal to admit that there are any causes for anxiety; 'rationalization, i.e. false reasoning to protect one's own self-esteem; and 'regression' which helps one to defend oneself against anxiety by reverting to an earlier stage of development or way of behaviour, e.g. when a child reverts to bed-wetting on the birth of a new baby in the family.

The most constructive of the defence mechanisms is 'sublimation' which takes place when we channel neurotic anxiety into an acceptable form of behaviour in order to 'do something' with that anxiety without destroying ourselves or others. Most housewives I think will admit to sometimes dealing with their anxiety or anger about a situation by vigorously cleaning the house!

As many of our children have very real as well as imagined anxieties it is unrealistic to think that they will be able to cope with their lives without employing some means of defence and therefore the old idea of directing a child's aggression and energy into 'useful channels', e.g. sport, helping other people, doing an activity at which they shine, is founded on firm psychodynamic theory.

Many therapists since Freud, have built on the basic ideas taken from psychoanalysis and developed them into specific treatment models.

The distinguishing feature of these later models, e.g. Carl Rogers' Non-Directive Therapy, Fritz Perls' Gestalt Therapy, and Eric Berne's Transactional Analysis is that they are not as determinist in outlook as the strictly Freudian model. By this I mean that, although they acknoledge the vital importance of early influences on the developing personality of the child, they believe in the possibility of change through therapeutic intervention. To people in our professions this optimism is of prime importance and the models of treatment mentioned above are well worthy of consideration by practitioners wishing to work in a psychodynamic way.

Summary.

In this section we have taken a very brief overview of one or two of the major tenets of the psychodynamic model of treatment. The importance of affect or feelings has been stressed as a key factor in bringing about a reduction in unhelpful anxiety and in helping the child to gain insight into his perceptions and behaviours and thus to bring about change and reduce maladjusted behaviour. The importance of the transference and counter-transference relationship has been touched upon as have also the principle of defence mechanisms and the importance of understanding feelings of ambivalence.

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The Cognitive Model

A key to understanding the cognitive approach to treatment lies in accepting the statement of Albert Ellis, one of the well-known cognitive therapists, that therapy 'deals with all kinds of irrationalities, illogicalities, superstitions, and unrealistic statements that people devoutly believe and use in a self-defeating way'. In other words, it is how we think which determines how we feel and how we behave. Ellis called his particular cognitive model of treatment 'Rational Emotive Therapy' and, as the title implies, although emotions are of great importance they are seen as following the beliefs which someone has about themselves or others.

When we listen to what our children say about themselves and about the people who affect their lives we are often amazed at what we perceive to be the inaccuracy of their statements. For example, how often do we hear a child say "Nobody likes me"; "I will never be able to learn to read"; "I am so ugly"; "Everyone is against me"?

Running through these types of statements is a feeling of helplessness and dependency which can, in turn, give us as therapists an equal feeling of inadequacy in dealing with the child's problems.

In order to clarify and understand how the child has reached those decisions about himself we must also be prepared to look at our own way of viewing ourselves and the world.

Often when reading a referral or report on a particular child we seem to be learning more about the person who has written the report than about the child! When we describe or assess a child it is our perception of the child that we are describing. Someone else may perceive the child in a totally different way. How often have we come across a child who appears to be one type of person at home and a totally different type of person at school or, similarly, in relation to one adult as opposed to another - the 'well, he's no trouble for me' syndrome!?

If we are to take a primarily cognitive view of personality and therefore of how to treat unhappy, disturbed personalities, our starting point must be to try to understand the child's perception of himself and his world and to be aware of our own subjectivity in relation to our perception of him. As has been suggested, it is the irrationality of the beliefs which a person holds about himself and his feelings of helplessness in the face of those beliefs which leads him to become unhappy, frustrated and maladjusted.

Some of the most common irrational beliefs which Ellis identified from his work with patients were:

(1) I must have approval from everyone I find significant or care about;

(2) I mustn't try anything new in case I fail in which case everyone would reject me;

(3) If people do something which I don't understand or like they are thoroughly bad;

(4) If I am frustrated in any small way it is the end of the world;

(5) I am helpless to do anything about my own life; everything that happens to me is someone else's fault and I have no control whatsoever about what I do or what is done to me.

We all, I am sure, have some or all of these feelings from time to time but it is the extreme and rigid nature of these beliefs and perceptions which

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leads to maladjustment in the view of Albert Ellis and his co-therapists such as Aaron Beck and V. Raimy.

The first step in Ellis' model of treatment is to help the individual to be aware of his irrational beliefs and he does this by going through, in great detail, all the events of that day or the previous week which have led to the child feeling unhappy, angry or frustrated and asking him to look at his explanation for why those things happened. Most of the child's'explanations' will centre around his feelings of helplessness to do anything about these precipitating events and it is by helping the child to see what practical steps he is in fact capable of taking to avoid similar unhappy consequences that therapists like Ellis hope to bring about constructive change in the child's way of thinking which will, in turn, help him to feel better and behave more appropriately. His method is very confronting and challenging and requires a certain level of ability to verbalise which, in my opinion, limits the technique to use with older children or children with a fairly highly developed degree of verbal reasoning and articulation.

A cognitive approach to treatment which is more suitable to children of all ages and levels of intelligence is, perhaps, that of George Kelly.

According to Kelly, the ways in which we feel and behave are due to what he calls our construct system. A construct is an individual's way of looking at and interpreting events and constructs develop as we notice the similarities and differences in the people or events making up our daily lives.

To give an example from our own settings. If we have some lengthy experience in working with maladjusted children we will almost certainly, when we meet a new child, say to ourselves, or indeed to our colleagues something like 'she reminds me of such a child we used to have - though she is obviously not quite as aggressive and anti-authority'. From this 'construct' we will then go on to make predictions about how the girl will behave towards adults and the other children and what difficulties we are likely to have with her. If our perception of the first girl, based on our experience with her, is mainly positive then our expectations of the new girl will be similar. The mark of maturity, in Kelly's terms, is that we are able to broaden our construct system to include additional ways of looking at the 'new' girl, should our experience with her demand this. The same would apply if our original construct was a very negative one.

Someone who is maladjusted will stick rigidly to a construct even when experience proves him again and again to be wrong. Thus a child whose former experience has led him to develop a construct relating to, e.g. authority figures always hating him and trying to hurt him may be unable to revise that construct even when surrounded by authority figures who offer him nothing but good experiences and unconditional acceptance. At the root of this inability to stray away from a rigid construct system is anxiety and a very real fear of not being able to predict accurately what is going to happen next.

The aim of Kelly-type cognitive treatment, therefore, is to provide a safe and inviting environment in which a child can, like a scientist, test out new hypotheses about himself and those around him until he develops new and successful constructs which help him to predict accurately now what he and others will do in certain situations and in response to certain stimuli.

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Kelly's type of therapy is called 'fixed-role therapy' and encourages, usually through role play, a child to practise representing himself and behaving in new ways. To give an example from a therapy session which took place within my own school: through the use of the Repertory Grid Test, devised by Kelly to examine and identify problem areas within an individual's personal construct system, a girl I shall call Jane was discovered to have a very poor self concept based on her rigid construct about herself as being selfish and, therefore, unable to make friends. In the group therapy session which was to concentrate on Jane that week the group devised a 'new personality' for her in which she would be generous, considerate and caring for the other children. In order to help her rehearse and 'try out' this new personality she was given sweets and small toys which she could choose to keep for herself or give out to the group. Having chosen to give each of the treats away fairly to each member of the group she was then asked to say how she felt whilst doing it. Then each member of the group was asked to say how he felt about Jane's generosity. The feedback from all round was warm and positive and for the first time Jane saw the possibility of developing a new construct about herself and her peers.

Obviously a single therapy session such as this does not achieve miracles and the confidence to widen and adapt and re-adapt constructs in the light of new experience and so become a better adjusted person, with a greater ability to make accurate predictions, requires repeated rehearsal over weeks and months and sometimes years.

Summary.

In this section we have taken a brief look at the way the cognitive model of treatment is based primarily on changing thought processes in the belief that these changes will bring about change in feelings about oneself and others and, consequently, change in behaviour.

The general aims of the cognitive model of treatment have been seen to be (1) to identify and change misconceptions about self, others and events, especially those misconceptions which arouse neurotic anxiety, depression and hostility; (2) to give the child structured opportunities to provide a basis for new, rational beliefs; (3) to provide a safe yet experimental environment in which a child can rehearse the effects of these new more rational beliefs in terms of his behaviour and feelings.

Conclusion.

Having, within the limited scope of this article, examined three very different models of treatment, is it possible to draw any conclusions about their relative value in our disparate treatment settings?

The three models appears to isolate one form of human functioning, i.e. feeling, thinking, or learnt behaviour as the major contributory factor to the way our personalities develop and give us our capacity to lead a more or less adjusted and happy life.

My contention would be, however, that we and the children with whom we work are such complex creatures that it is more profitable to consider the interaction between thinking, feeling and behaving than to consider each of these aspects in isolation.

We could define maladjustment as an inability to integrate and organise successfully these three important components of human experience and postulate that the aim of all therapy, whatever the label we choose to put upon it, lies in the achievement of this integration.

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In day-to-day terms, however, we are faced with choosing methods, or treatment models, to deal with different children, with different problems in different situations. Perhaps it is more practical, and in the end more effective, to open oneself to the possibility of using a variety of treatment methods which will, hopefully, be tailored to the variety of the special emotional and social needs of the various children in our care.

In this way, we may decide that one child's problems have definitely arisen from learnt behaviour and that, therefore, some form of behavioural treatment would be most appropriate.

Another child may, we assess, have to deal with the repressed and destructive feelings has has about himself and others before he can progress towards changes in attitudes and behaviour. In which case, our first choice of treatment might be based on psychodynamic lines.

Yet another child may hold so many irrational beliefs about himself and his world that we feel that until some of these have been cleared away, through the use of a more cognitive approach to treatment, we and he are not going to make any progress.

I would like to conclude, therefore, where I began. No single model of treatment seems to give us the complete 'magic' answer to our problem in deciding how to treat each individual child who is sent to us for help.

If we are prepared to open our minds and hearts to the possibility of learning from the many models which have been evolved over the years, however, we may find some clues, some pointers and some support from fellow strugglers after a solution to our difficult, but always exciting and stimulating, task of finding ways in which to be of true service to the maladjusted children entrusted to us.

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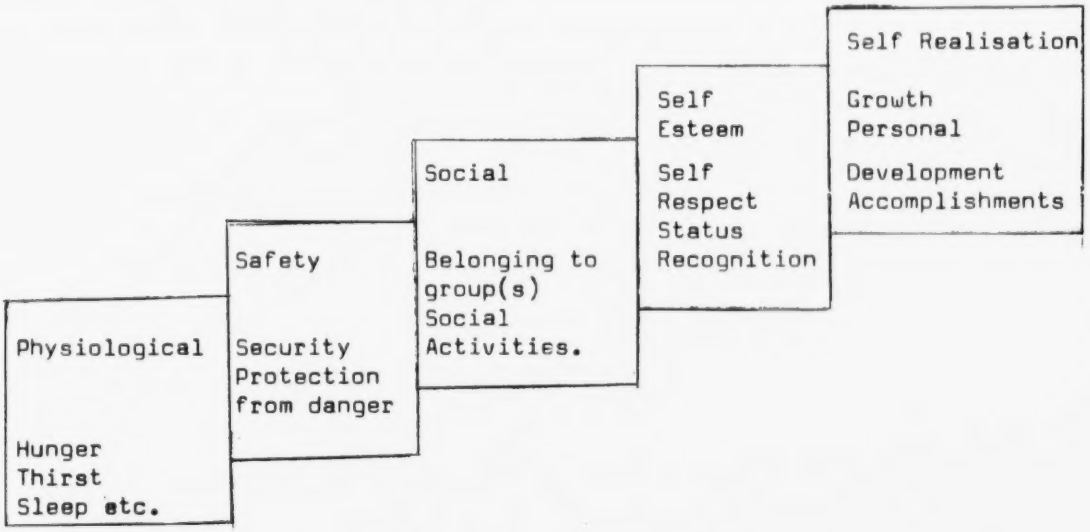
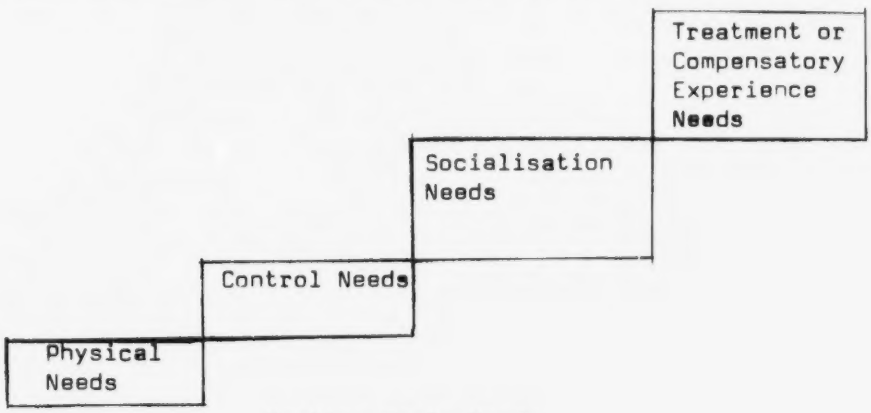
The Basic Needs of Children

Maslow - Hierarchy of needs.

Maslow propounder a theory that people are motivated by five basic groups of needs, which he called a 'hierarchy of needs', illustrated below. The primary need is that of physical survival, and until this need is met people are not able to satisfy needs further up the hierarchy. This is true of each successive stage.



Translated from the individual to group care the diagram below shows that physical care and control come before children can socialise or be 'treated'.



Meeting Basic Needs

Many children who enter residential care are children who for a variety of reasons have not had their basic needs met, particularly in early childhood. The starting point therefore for anyone caring for such children and trying to help them through their difficulties must be what are these basic needs and how can they now be met?

The most convenient way to look at needs is probably to split them up into groups, i.e. Physical, Intellectual, Emotional, Social and some would add Spiritual. A useful mnemonic for this is PIES(S).

Physical needs include sleep, food, exercise, clothing, warmth, shelter, comfort, health, hygiene, safety, and space. All these physical needs also effect the emotional well being of an individual. The connection between physical and emotional needs is clearly illustrated by the way that upset people may stop eating or over eat, or find it difficult to sleep or sleep well all the time. Plenty of food may be available for children

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in an establishment, but it will only meet their needs if attention is given to what, when, where and how it is provided. These are issues which staff groups have to discuss with childrens' emotional needs in mind if they aim to create an environment where children can grow and develop their potential.

Listed below are some intellectual, emotional and social needs to which readers will no doubt add according to their own personal values and how they perceive their own needs. This is an important element which adults working with damaged children have to be consciously aware of, so that it can be taken into consideration when looking at the individual and groups of children and how their needs can best be met.

Intellectual

Routine
Education
Play
Activities
Decision making
Opportunity to explore
Hobbies
Conversation
Stimulation
Observation
Guidance in thinking
Tasks to succeed at

Emotional

Love
Acceptance
Caring
Concern
Physical contact
Space
Privacy
Identity
Someone to identify with
Someone to trust
Security
Personal possessions
Conversation
Relationships at different levels (primary,secondary and casual)
Silence
Noise
Discipline (limits and control)
Hope
Opportunity for decision making
Opportunity for release of aggression
Standards
Opportunity for reparation
Sense of belonging
Opportunity to explore
Activities
Peer group relationships
Boundaries
Responsibility

Social

Models (re: conduct of relationships etc.)
Standards and values
How to behave in a socially acceptable manner
Awareness of other people as individuals
Consequences
How to make friends
How to overcome shyness
Knowledge of how the world works
Interaction with the community
Know how to distinguish between public and private behaviour
Awareness of the opposite sex.
Social skills e.g.using telephone, value of money etc.
Awareness of cultural differences.
Opportunity to explore
How to behave in a group
How to cope with daily living
Activities

Spiritual.

Philosophy of life.

Cont....

It may be a useful exercise to look at each child within an establishment together with a list of needs to see if and how needs are being met. Different establishments will have different resources to draw on internally and externally and so will each individual within the establishment, both adult and child. If all available resources are to be known and used, considerable discussion has to take place between the adults involved who have to be prepared to be open and frank with one another.

Focal Points in the Day.

A useful way of approaching the difficult task of meeting children's needs within a residential establishment is to look at focal points during the day and the worker activities around them.

Chris Payne - a lecturer at the National Institute of Social Work - produced the chart below which I feel is a helpful start to the above process. Each establishment however will have particular times of day in addition to these that it will want to analyse in more detail as well as their own particular customs and practices.

FOCAL POINTS	GOAL	DIRECT WORK (INSTRUMENTAL LEVEL)	DIRECT WORK (EXPRESSIVE LEVEL)	INDIRECT WORK
WAKING-UP	ACHIEVING A GOOD START TO THE DAY	WASHING) DRESSING)HELP WITH TOILETING)	PROVIDING EMOTIONAL FIRST AID FOR DEPRESSED AND WITHDRAWN RESIDENTS WHO CANNOT FACE THE DAY	SCENE-SETTING - DRAWING CURTAINS AT THE APPROPRIATE TIME
IN-BETWEEN TIMES	AVOIDING 'VOIDS'	PROVIDING GAP-FILLING ACTIVITIES: TOPICS FOR CONVERSATION; ASSISTANCE IN WALKING AND MOBILITY	CALMING RESIDENTS WHO WANT TO GET THE DAY OVER BEFORE IT HAS STARTED	ENSURING SUPPLY OF SUITABLE MATERIALS; REDUCING HURDLES AND OBSTACLES
MEAL-TIMES	ACHIEVING PERSONAL AND SOCIAL SATISFACTION	FEEDING DISHING OUT FOOD	ASSISTING, ADVISING, SUPPORTING, INTERVENING AT INDIVIDUAL AND GROUP LEVELS	SUITABLE FOOD: CHECKING ON TERRITORIAL ARRANGEMENTS: SEATING: STRUCTURING THE OCCASION SUITABLY
USE OF PROGRAMME	TO PROMOTE DEVELOPMENT 'LIFE ENRICHMENT'	DEVELOPING AGE AND TIME APPROPRIATE ACTIVITIES FOR INDIVIDUALS AND GROUPS	STIMULATING, EDUCATING, BEFRIENDING, TALKING, LISTENING: INDIVIDUALS AND GROUPS	PREPARING THE SCENE: STRUCTURING THE ENVIRONMENT APPROPRIATELY ETC.
GOING TO SLEEP	TO PROVIDE A ROUTINE THAT RELAXES	BATHING TUCKING IN	ALLAYING FEARS: ANXIETIES ABOUT LOSS, SEPARATION: CALMING, SOOTHING	PROVIDING SNACKS, SOOTHING MUSIC, SCENE-SETTING.

Reasons for Stealing

Most behaviour problems can be seen as symptoms of unmet need. A useful list of symptoms arranged in sevon groups, can be found in Appendix B of the Underwood Report, published by the Ministry of Education in 1955.

Stealing is a symptom that creates much hostility and anxiety in both adults and children who are involved with the child exhibiting it. It is because of this, that we should look at it in more detail. If we understand the reasons for a child behaving in a difficult manner, we are more likely to respond helpfully and appropriately.

Below is a list of 23 possible reasons for stealing:-

1. Because the child has always had what he wants.
2. For the thrill of it. (countering boredom).
3. Challenging the system/anti authority.
4. Desire to be punished through feelings of guilt.
5. Feeling that it is justified.
6. Feeling deprived, or more rarely actual physical deprivation.
7. To make friends. (Give away the proceeds).
8. To feel approved of by a group. (being dared).
9. To stay a part of a group. (fear of rejection by group).
10. It is part of a sub culture. (learnt behaviour).
11. To attract attention.
12. To make one feel clever.
13. Identity. (It is the only thing one is recognised for or good at).
14. Testing out places and people.
15. Family influence (identifying with a criminal parent - bad model).
16. To hurt someone.
17. To keep a part of a person.
18. Difficulty in differentiating between yours and mine.
19. As a substitute for love.
20. Confusion between personal and communal property.(particularly in institutionalised children).
21. Envy, jealousy or greed.
22. Not seperated out from mother. (links with 18, the child never established his own identity or boundaries.)
23. It has become a habit.

It may be useful for a staff group to discuss how they might try to differentiate between the types of stealing and if and how they would respond to different children who stole for different reasons.

Unfortunately, in some ways, stealing is a bad example because many children continue to steal after the original reason has been removed, because it has become a habit. Pointing out the consequences of stealing in society may be the only course of action in these cases and they may have to 'take their chance' eventually.

Innate Conflicts in Residential Placement.

When groups of adults and children live together a number of tensions arise. If the adults concerned do not see or understand how these come about then inevitably they will create conflict. Many tensions can stem from failure to agree about a number of very basic issues which cannot be avoided and can be very derisive.

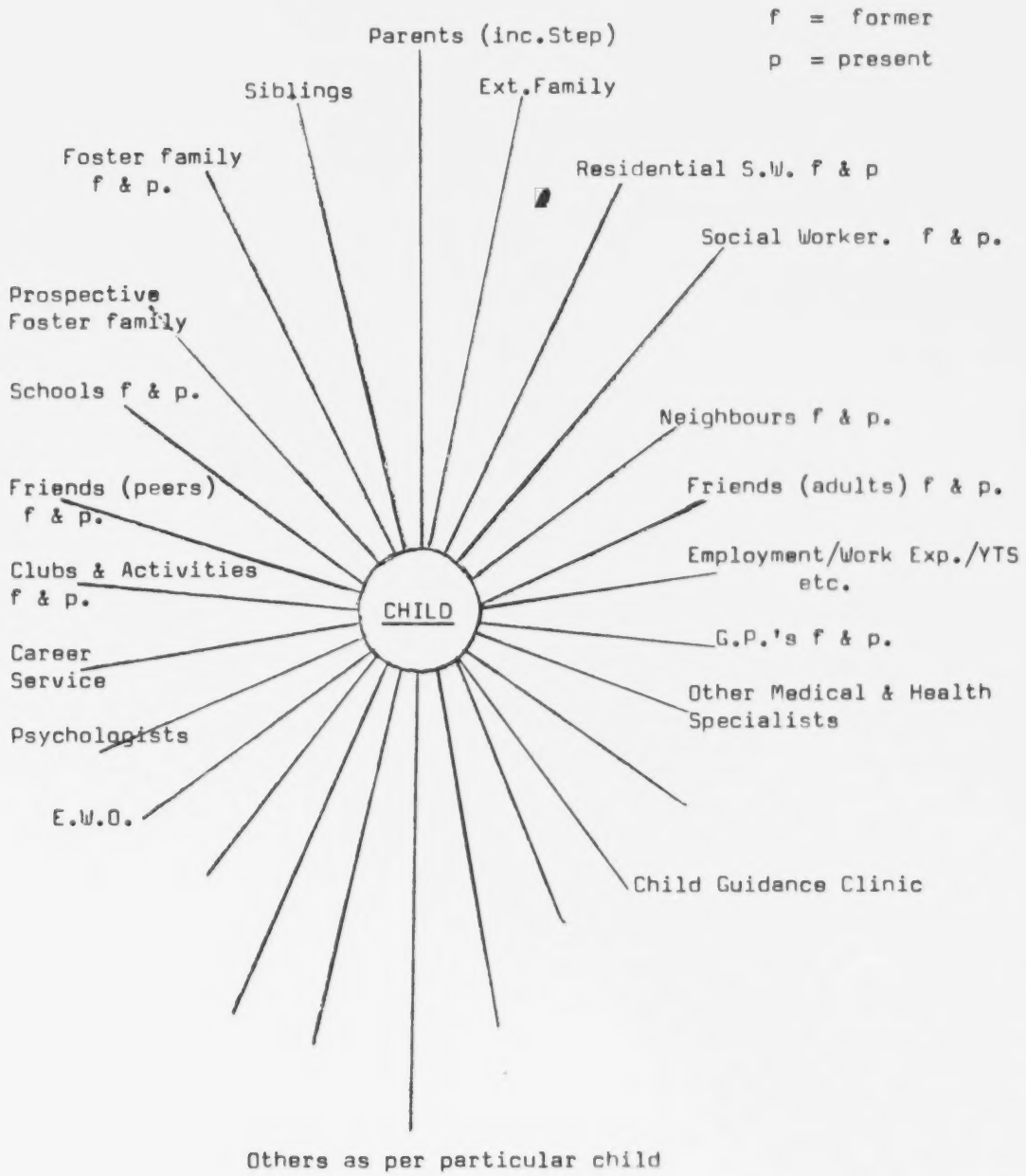
Listed below are 19 pairs of opposing concepts: Hopefully workers will not be polarised at one end of the other, but somewhere along the continum between the two. Workers should be aware of their own and each other's stance on these issues and an establishment should try to establish a consensus or corporate view.

1.	Dependence of individuals	Independence
2.	Individual Identity	Conformity (Sociably Acceptable, Group behaviour)
3.	Exploration and Physical Testing	Safety
4.	Relationships in depth and conflict	Easy superficial relationships and smooth running of establishment.
5.	Lack of personal care	Over emphasis of health and hygiene.
6.	Growth and Change	Consistency and Security.
7.	Individual needs	Group needs
8.	Individual activities, hobbies etc. (avoidance of group interaction)	Group activities and inter-action (promoting group inter-action).
9.	Looking towards future and Rehabilitation (Insecurity)	Concentrating on present (security)
10.	Freedom	Control.
11.	Privacy	Group living
12.	Providin for special needs.	Fairness.
13.	Maintaining outside contacts (escape from living group)	Remaining within establishment (working our relationships and conflicts within the group).
14.	Adult needs	Child needs and group needs.
15.	Adult rights	Child and group rights.
16.	Outside influence from the past.	Present influences and relationships.
17.	External constraints. (The Law, Management Policy, Neighbours, and relatives.)	Needs of child - as seen by the establishment.
18.	Understanding	Punishment
19.	Care	Education.

The Child, Family and Community

At one time when children entered residential establishments the only concern of the staff there was to help them as individuals with their difficulties. The child is now more often seen as part of a network of people who have to be considered and worked with if the child is to be returned to the community. Children will return to their own family, or a substitute family, or become independent; they will only move successfully into the future if they have been helped to accept the reality of their past and present situation(s) and see themselves as a "whole person"

Below is a chart showing some people who may be important in a child's life.



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Obviously if you look at a child as part of such a network the complexity of each child's situation becomes apparent. It is important to know the significance of other persons and agencies in the child's life; all workers involved must have a clear idea of their respective roles and responsibilities towards the child, the family and all others concerned.

A useful way of talking with the child about his knowledge/feelings about the past, maybe the compiling of a 'life history book' with the child. Books and information about how to set about this task can be obtained from B.A.A.F. (British Agencies for Adoption and Fostering) 11, Southwark Street, London SE1 1RQ.

When a child is admitted to a residential establishment the workers concerned should have knowledge of the child's past and present situation, their respective roles and responsibilities and what is expected to be achieved during the child's stay in the establishment, together with an estimated time scale.

H.M.I. ASSESSMENT SHEETS.

During the passage of the Education Bill (later to be enacted as the 1981 Education Act) through Parliament the then Minister of State promised the House of Commons that no independent school would be approved as suitable for pupils, for whom a "Statement of Special Educational Need" had been prepared by a local education authority, without an inspection. Thus it was that HM Inspectorate faced the task of mounting such inspections in all those schools - about 180 in number - who had applied for approval under the Act.

In order to facilitate this operation and to ensure that it might be completed in a reasonable time, a set of schedules was developed, covering four main aspects of the schools to be visited, namely: Educational Arrangements, Care Arrangements, Staffing and Accommodation and Resources. It was also felt that these schedules would impose and acceptable degree of uniformity upon the process of inspection and, to some extent at least, ensure a consistency of judgement on the part of the inspecting teams.

The schedules took the form of a number of questions which HMI were required to ask themselves about what they saw in the schools. Some of these questions concerned matters about which there could be no doubt, since they were covered by regulations or by agreed policy; most required answers based upon the judgment of the inspection team. It was to help team members to come to their decisions that closely detailed schedules were devised: it is those detailed schedules concerned with Care Arrangements which are published here. By using them it proved possible to come to reasonable conclusions about the standard of child care existing in a particular establishment. No wider claims should be made for them.

Those who devised the schedules and used them widely are only too well aware of their shortcomings. Such instruments cannot, for example, catch the atmosphere of a school or give due importance to the quality of interpersonal relationships which exist there. Perhaps this was an attempt to measure that which cannot be measured. Nevertheless we believe that all concerned in this operation learned a great deal in the process and that the Child Care schedules, with all their imperfections, helped sensible decisions to be reached and, in so doing, broadened our understanding of the parenting task.

We present the assessment sheets complete including the sheets directly related to teaching provision because they were part of an integrated assessment.

School._____

SUMMARY SHEET

STAFFING

Teaching

Are there sufficient teachers of QT status?.....
Are staff organised and deployed satisfactorily?.....
Are appropriate arrangements made to allocate staff responsibilities.

Ancillary.

Are there sufficient ancillary staff?.....
When employed, are they deployed appropriately?.....

Support.

Are adequate arrangements made for medical and dental care?.....
Are there sufficient paramedical staff (where appropriate)?.....
Are the paramedical staff appropriately deployed(if appropriate)?
Is there sufficient other outside support?.....

Care

Are there sufficient care staff?.....
Is there relevant experience and expertise represented?.....
Is the male/female balance appropriate?.....
Are care staff suitably and appropriately deployed?.....
Are appropriate arrangements made to allocate staff responsibilities?
Where care extends beyond school terms, are sufficient and suitable care staff employed?.....

Communications and in-service training.

Are appropriate arrangements made for internal staff communication?
Are appropriate arrangements made for in-service training of staff?

School_____

SUMMARY SHEET

EDUCATIONAL ARRANGEMENTS.

I. Academic organisation.

a) Do the class groupings facilitate the children's work?.....
b) Is the allocation of classroom time appropriate?.....
c) Is effective use made of a timetable?.....
d) Is the selected organisational mode appropriate?.....
e) Are there satisfactory and effective organisational arrangements for meeting particular needs?.....

II. Curriculum.

a) It the curriculum well documented?.....
b) Are the documents of an appropriate quality?.....
c) Do they influence the work positively?.....
d) Is the curriculum appropriate for the school as a whole?.....
e) Does the curriculum meet the educational needs of individuals?...
f) Is there satisfactory perparation for the adult world?.....

III. The delivery of the curriculum.

a) Are appropriate teaching styles adopted?.....
b) Are sufficient and satisfactory learning modes provided?.....
c) Is the learning situation satisfactory? (Refer to schedules).....
d) Is there continuity of curricular experience?.....

IV. Assessment and record keeping.

a) Is there a satisfactory and effective assessment policy?.....
b) Are satisfactory assessments made (using tests and/or other procedures?).....
c) Are teachers' records generally of a satisfactory quality?.....
d) Is effective use made of assessment and records (curricular
e) Are the arrangements for other school records satisfactory?.....

V. Liaison and continuity.

a) Are there satisfactory and effective admission arrangements?.....
b) Are satisfactory and effective arrangements made for liaison during the pupil's stay in school?.....
c) Are there satisfactory and effective discharge arrangements?.....

SUMMARY SHEET

CARE ARRANGEMENTS

I. Evidence of a planned approach.

a) Are the arrangements adequately documented?.....
b) Are roles and functions defined, understood and accepted by staff?
c) Is there e idence of a unified approach?.....
d) Are child-care and teaching elements co-ordinated?.....
e) Is there a systematic induction of new staff?.....

II. Physical care.

a) Are health and hygiene arrangements satisfactory?.....
b) Is the food and its preparation satisfactory?.....
c) Are arrangements for the medical care of pupils satisfactory?....
d) Are arrangements for clothing and footwear satisfactory?.....

III. Personal relationships.

a) Do staff accept a child 'as he is'?.....
b) Are children treated as individuals to be respected as such?.....
c) Are there good staff/staff relationships?.....
d) Are there good staff/pupil relationships?.....
e) Are there good child/child relationships?.....
f) Does the organisation facilitate good relationships?.....

IV. Meeting emotional needs.

a) Does the school meet the childrens' need for security?.....
b) Are children re-assured that they are worthwhile?.....
c) Are children's needs to be private adequately met?.....
d) Are children adequately stimulated with new experiences?.....
e) Are children encouraged to receive and give affection?.....

V. Encouraging personal growth and maturity.

a) Is a suitable and balanced range of activities provided?.....
b) Are opportunities provided for choosing and choice?.....
c) Is independence and mobility fostered?.....
d) Is care and concern for others encouraged?.....
e) Are children provided with opportunities to accept responsibility?.

VI. Effectiveness of routines.

a) Are arrangements for 'before school' routines satisfactory?.....
b) Are mealtime routines satisfactory?.....
c) Are evening and weekend arrangements satisfactory?.....
d) Are bedtime routines satisfactory?.....
e) Are appropriate arrangements made for night supervision?.....
f) Are satisfactory arrangements made for pupils during the holidays?..

VII. Sanctions.

a) Is there an appropriate and known policy concerning sanctions?.....
b) Is the practice effective and consistent with policy?.....

SUMMARY SHEET

ACCOMMODATION AND RESOURCES

Teaching accommodation

Are there enough teaching spaces (including specialist)?.....
Are all teaching spaces of appropriate size (in relation to disabilities)?.....
Are classrooms suitably heated, lit and ventilated?.....
Is there sufficient and suitable classroom furniture?.....

Day-time washroom facilities.

Do the facilities for children comply with regulations?.....
Do the facilities for staff comply with regulations?.....

Bedroom accommodation

Do the sizes of bedrooms comply with regulations?.....
Are bedrooms suitably heated, lit and ventilated?.....
Are bedrooms maintained to a satisfactory standard of repair, decoration and cleanliness?.....
Are bedrooms suitably furnished (beds and storage?).....
Has consideration been given to the bedroom accommodation for older secondary age pupils?.....

Residential washroom facilities.

Are there sufficient baths?.....
Are there sufficient wash basins?.....
Are there sufficient WCs?.....

Living accommodation

Is sufficient living accommodation provided for all pupils?.....
Is it suitably furnished?.....

Meals

Are the facilities for preparation of meals and food storgage satisfactory?....
Are there suitable dining facilities?.....

Sick room and Medical room

Is the sick room and medical room accommodation satisfactory?.....

Staff accommodation

Is there a room for use by the teaching staff?.....
Is separate provision made for sleeping, eating and washing for residential staff?.....

Miscellaneous accommodation

Are appropriate arrangements made for sewing, airing and storage?.....

Organised games and recreation

Is there a suitable space for outdoor recreation and games?.....
Is there adequate hard surfaced play area on site?.....

Resources and equipment.

Is there sufficient and suitable apparatus and equipment?.....
Are there sufficient and suitable books?.....
Are there sufficient and suitable consumables?.....

I Evidence of a planned approach

(a) Documentation

i. Is there a written statement?
ii. Are any of the care practices documented (other than rotas)?
iii. Where there are policy/practice documents, do all care staff have copies?

(b) Roles and functions defined, understood and accepted

i. Written job descriptions.
ii. Staff awareness of roles and functions and how they fit into an overall pattern.
iii. Arrangements to facilitate the exercise of these roles and functions.

(c) A unified approach

i. Staff doing and saying similar things.
ii. Common practice re routines.
iii. No contradictory words or actions.
iv. Pupils not able to play off staff one against the other.
v. Little attempt by pupils to do so (i.e. aware that it will not work).

(d) Co-ordination of child-care and teaching elements.

i. Good lines of communication.
ii. Acceptance by both sets of staff of the value of each other's contribution.
iii. Follow-up activities/interests/discussions initiated in school (or vice versa).
iv. Interchangeability of staff where valuable.
v. Joint discussions/staff meetings/case conferences.

(e) Systematic induction of new staff

i. Specific arrangements and support.
ii. Provision of adequate information.
iii. Careful programming of new members of staff.
iv. Personal counselling.

II Physical Care

(a) Health and Hygiene

i. Existence of a general air of wellbeing.
ii. State of personal cleanliness.
iii. Sensitivity of arrangements for ensuring good personal care.
iv. Arrangements for enuretics and encopretics. Are these sensitive as well as efficient?
v. Arrangements for children to be active and energetic.
vi. Cleanliness and care of environment.

(b) Clothing/footwear

i. Quality and fit of clothes.
ii. Appropriateness of design and material for the age-group/sex.
iii. Opportunity for children to exercise choice.
iv. Cleanliness and frequency of changing clothes.
v. Footwear - fit, state of repair, missing laces, inappropriate use of footwear.

(c) Feeding

i. Appropriateness of diet (is fresh fruit regularly provided?)
ii. Quality of food preparation.

(Catering arrangements at any school are subject to the Food Hygiene (General) Regulations 1970 (SI No 1172). Responsibility for reinforcement rests with the Local Authority's Environmental Health Department).

(d) Medical care

i. Arrangements for medical registration, consultation and treatment (including medical on admission).
ii. In-school treatment of minor injuries and ailments.
iii. Arrangements for storage and dispensing medicines (and disposing of unused drugs).
iv. Arrangements for vaccinations and immunisations.
v. Any involvement of community health services.

III Personal relationships

(a) Acceptance of the child 'as he is' (not his behaviour)

i. Staff articulate this point of view.
ii. Children not rejected or reviled by staff - their 'good' points may be mentioned.
iii. Acceptance of children's attempts at reparation.
iv. No pillorying of individuals.
v. Sparing use of exclusion from activities etc. as a sanction.

(b) Children treated as individuals to be respected as such

i. Staff articulate this point of view.
ii. Minimal regimentation.
iii. Use of children's christian names.
iv. Allowing the child to individualise his environment (eg his bedspace).
v. Showing respect for child's point of view (not necessarily agreeing with it).
vi. Finding out the things a child 'is good at'.
vii. Total attention given to a child when appropriate.
viii. Sparing use of group pressures for general sanctions.

(c) Staff/staff relationships (an example to children)

i. Respect for one another. Courtesy.
ii. Cooperative working - mutually supportive.
iii. Fairness in distribution of duties, particularly the unpleasant ones.
iv. Supportive attitudes of senior staff.
v. Effective grievance procedures at all levels.

(d) Staff/pupil relationships

i. Fairness on the part of adults.
ii. Not leaving anybody out.
iii. Making time for a child.
iv. Sharing of interests, enthusiasms and activities.
v. Mutual understanding of each others feelings.
vi. Induction of the 'new' child.
vii. Effective procedures for settling disputes. No grudge-bearing on the part of adults.

(e) Child/child relationships

i. Caring for one another (often in small ways).
ii. Children encouraged to learn effective ways of dealing with quarrels and disagreements.
iii. Children showing insight into other's problems or difficulties.
iv. Concern for compatability of groups in dormitories etc.
v. Opportunities are given to share.
vi. Watchful control of bullying and intimidation.
vii. Justice is seen to be done.

(f) Organisational arrangements for developing a satisfactory pattern of relationships

i. An awareness of the need for a stated strategy.
ii. Designated responsibility for devising the strategy.
iii. Equitable organisational arrangements.
iv. Understandable and effective grievance procedures.

IV Meeting emotional needs

(a), Need for security

i. Well understood framework of routines. Essential minimum - unrestrictive maximum.
ii. Setting of limits to behaviour and consistency in their application.
iii. A predictable environment, but not inflexible
iv. Warm, caring approach by adults.
v. A personal sense of 'territory'.

(b) Need for reassurance that people care/see the child as worthwhile

i. Staff find time for the children.
ii. Staff listen to the children.
iii. Opportunities provided for discussion, advice and counselling.
iv. Staff treat the children and their property/products with respect.
v. Practical expressions of caring.

(c) Need to be private

i. Provision of places for privacy
ii. Provision of opportunities for privacy - not always 'organised'.
iii. Respecting the child's right to be private.

(d) Need for new experiences and opportunities.

i. Good range of activities provided.
ii. Getting to know children's previous experiences and attempting to 'fill gaps' and extend.
iii. Vicarious experience through stories, staff's own adventures etc.

(e) Need to receive and give affection

i. Unembarrassed acceptance by staff of affectionate gestures, acts, gifts.
ii. Unsentimental expressions of affection by staff.

V Encouraging personal growth and maturity.

(a) Suitable and balanced range of activities

i. The range should include activities other than physical, i.e. table games.
ii. Some activities outside the school, ie local clubs.
iii. Sharing enthusiasms - activities relating as much to interests and enthusiasms as to an arbitrary list.

(b) Choosing and choice

i. Opportunities for choice created in all aspects of the school's life.
ii. Opportunities for choice should be related to the maturity of the child, is not beyond their competence or beneath their dignity.
iii. Opportunites to opt out.

(c) Independence and mobility

i. Evidence of a considered anproach to the development of independence.
ii. Practical experience in travelling/using public facilities/ self-care/money.

(d) Care and concern for others

i. Serving the school community.
ii. Serving the local community.
iii. Extent to which the arrangements reflect the growth in maturity of older pupils?

(e) Accepting responsibility

i. Provision of opportunities for pupils to accept responsibility: for self and own behaviour/for others.
ii. Opportunities to share in decision-making.

VI Effectiveness of routines

(a) Before school

i. Rising, bedmaking, personal cleanliness.
ii. Routines not to be rushed.
iii. Transition from 'home' to school (not too gentle nor too pronounced).

(b) Mealtimes.

i. Involvement with staff.
ii. Civilised arrangements.
iii. Opportunities for social skills training.
iv. Presentation of food.
v. Are meals appropriately spaced?
vi. Is the last meal of the day too early? (Generally not before 5.30 p.m. Related to whether any more food or drink is available later on).
vii. Awareness of the psychological importance of food.

(c) Evening activities and weekends

Appropriateness of activities - particularly where schools have a wide variety of boarding arrangements (eg weekly, fortnightly etc).

(d) Bedtimes

i. Are times of going to bed appropriate?
ii. Are there sufficient adults for pupils to talk to/play with at bedtime?
iii. Is the pace appropriate?
iv. Is there a gradual settling down process?
v. What about children who are frightened to go to sleep?

(e) Night supervision.

i. At least two available on the premises. Ideally in a mixed school one of each sex.
ii. Are there adequate arrangements for children to contact duty staff (ask children!)

(f) Evidence of appropriate care during holidays.

FOR ESTABLISHMENTS OFFERING EXTENDED CARE (50-52 weeks etc.)

A differential approach to care should be apparent between what is offered during term time and what occurs during school holidays.

TRAINING MATERIALS AND OPPORTUNITIES

Every institution catering for disturbed children should have a training policy but it may find difficulty in providing a good training programme. The following suggestions may be helpful in giving leads to available training courses and materials.

1. The Association has a complete list (1985) of all accredited Education and Social Services courses which have a component dedicated to disturbed children. Because of projected changes this will be altered over the next year or two but we will try to keep it up to date.

2. The Association Newsletter is proving a useful way of keeping members in touch with new initiatives and with self-help groups.

3. The Open University Course "Caring for Children and Young People" is proving useful. It is a basic short course using a variety of materials including audio and video tape. The package includes 12 student boxes and leader material. We would stress that in our view it gives best value only if it is led by an experienced tutor. Details and cost are available from local Open University centres: as the cost is high a number of places have decided to share and this gives the benefit of bringing workers together.

4. E.S.C.A.T.A. have a course which is similarly structured. "Handling Aggression and Conflict". Details are available from E.S.C.A.T.A, 6 Pavilion Parade, Brighton, Sussex BN2 1RA.

5. The Social Care Association, 23a Victoria Road, Surbiton, Surrey KT6 4JZ mounts short courses which are of interest to those working with disturbed children. This Association is concerned with the whole range of residential care and does not restrict itself to our particular clientele.

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R E S P O N S E

Without your response we cannot know how this pack has been received, whether to produce more material for this pack or what it should consist of. Please return this form to us.

Name.....

Address.....

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Comments and suggestions for future material.....

I/We would like to contribute material on.....